(2) Acute care hospitals that do not qualify under the criteria in (1) but have a low-income inpatient utilization rate exceeding 25% will receive the following payment incentive:

(a) The prospective rate will be adjusted upward by 2% for each percentage above 25% up to a cap of 10%.

(b) No total payment of the disproportionate share adjustment will exceed 80% inpatient charity care plus 80% of inpatient bad debt. All inpatient charity care and inpatient bad debt will be determined by the latest industry complete Hospital Joint Annual Report as submitted to the State center of Health Statistics.

(c) Low-income utilization rate will be calculated as follows from information obtained from the latest industry complete Hospital Joint Annual Report as submitted to the State Center of Health Statistics. The sum of:

o Total Medicaid inpatient revenues paid to the hospital, plus the amount of the cash subsidies received directly from State and local governments in a cost reporting period, divided by the total amount of revenues of the hospital for inpatient services (including the amount of such cash subsidies) in the same cost reporting period; and,

o The total amount of the hospital's charges for inpatient hospital services attributable to charity care (care provided to individuals who have no source of payment, third-party or personal resources) in a cost reporting period, divided by the total amount of the hospital's charges for inpatient services in the hospital in the same period. The total inpatient charges attributed to charity care shall not include contractual allowances and discounts (other than for indigent patients not eligible for Medical assistance under an approved Medicaid Sate plan) that is, reductions in charges given to other third party payers, such as HMO's, Medicare or Blue Cross.

(d) No disproportionate share payment will be made to hospitals that do not have at least two obstetricians with staff privileges at the hospital who have agreed to provide obstetric services to individuals entitled to such services under the State Medicaid Plan. The only exception will be made to hospitals which provide services to inpatients that are predominantly individuals under 18 years of age or who did not offer non-emergency obstetric services as of December 21, 1987.

(3) Each year a redetermination of the MDSA will be made at the same time the new pass through component is determined. This determination will be made on the basis of the best information available. Once the determination is made, it will not be changed until the next scheduled redetermination. The effective date will coincide with the new pass through adjustment.

(4) Beginning July 1, 1988 the disproportionate share adjustment will be paid on a monthly basis and established in June of each year. The monthly payment will be prospective based on the disproportionate share adjustment multiplied by the anticipated number of Medicaid days for the upcoming fiscal year July - June. This will be estimated based on projections from historical experience and the addition of any expected improvement.

(5) Beginning January 1, 1991, any hospital designated as a perinatal center by statute or regulation and with a service plan approved by the Tennessee Department of Health and Environment, Maternal and Child Health Section or any hospital providing without charge services to high-risk, multi-handicapped persons under age 21 who are in need of specialized children's services, shall, because of the extraordinary risk and expertise involved in treatment of these individuals, be eligible to receive an adjustment not to exceed the uncompensated cost for perinatal services and services to handicapped children at each hospital for the state fiscal year. The total uncompensated care for each of the qualified providers will be divided by the total anticipated Medicaid days for the same period in order to determine the amount to be added to the disproportionate share adjustment calculated in (1) and (2) above. This new adjustment will be multiplied by the total anticipated Medicaid days for the period. This adjustment will be added to and not subject to any limits that are included in the above formula.

(6) Beginning July 1, 1991, any acute care hospital qualifying for a disproportionate share adjustment under the qualifying criteria listed in (1) and (2) above and having at least 1,000 projected Medicaid days and having a Medicaid utilization ratio that exceeds the industry average utilization ratio which is computed by dividing the available hospital days by the Medicaid industry days will be eligible for an additional enhanced disproportionate share adjustment based on the following:

a. The prospective rate will be adjusted upward by an amount equal to the difference of the hospital's Medicaid utilization ratio and the industry average utilization ratio multiplied by a factor of 9.45.

b. The enhanced MDSA payment will be based on the enhanced disproportionate share adjustment calculated in (a) above multiplied by the anticipated number of Medicaid days for the upcoming fiscal year July through June.

c. The sum of the MDSA payment calculated in (1), (2), and the enhanced payment computed in (6) cannot exceed the aggregate sum of inpatient and outpatient charity care and bad debt charges and Medicaid and Medicare contractual adjustments converted to cost based on the latest industry complete Hospital Joint Annual Report as submitted to the State Center of Health Statistics.

d. For the period December 15, 1991 through December 31, 1991 an additional payment will be made to qualifying hospitals in accordance with the following formula:

1. The prospective rate will be adjusted upward by an amount equal to the difference of the hospital's annual Medicaid utilization ratio and the annual industry average utilization ratio multiplied by a factor of 800.

2. This additional enhanced MDSA payment will be based on the enhanced disproportionate share adjustment calculated in 1. above multiplied by the anticipated number of Medicaid days for the fiscal year July through June.

3. The sum of the MDSA payment calculated in (1), (2), and the enhanced payment computed in (6) cannot exceed the aggregate sum of inpatient and outpatient charity care and bad debt charges and Medicaid and Medicare contractual adjustments based on the latest industry complete Hospital Joint Annual Report as submitted to the State Center of Health Statistics. The amount paid during this period, December 15, 1991 through December 31, 1991, will not be included when applying the limit described in 6c.

4. This methodology will be effective from December 15, 1991, through December 31, 1991. After that time, all payments will be made in accordance with the methodology approved in the State Plan and in effect for July 1, 1991.

(7) Effective October 1, 1992, the Medicaid disproportionate share adjustment will not be determined per above, but will be determined as described as herein. Hospitals having over 1,000 cost report patient days attributable to patients determined eligible for Medicaid by the state of Tennessee or a Medicaid utilization ratio over 7.94% or having a low income utilization ratio equal to or greater than 25% will be provided a payment incentive (MDSA). The MDSA will be the higher of (a), (b), or (c), and the sum of (a), (b) or (c), whichever is higher, plus (f) cannot exceed 40% of inpatient and outpatient charity charges plus Medicare and Medicaid contractual adjustments adjusted to cost. For the purposes of this calculation, Medicaid days will not include days reimbursed by the Primary Care Network. For the purposes of this calculation charity unless otherwise specified, will be defined as inpatient and outpatient charity charges (including medically indigent, low income, and medically indigent other), bad debt, and Medicare and Medicaid contractual adjustments adjusted to cost. Charity will include charges for both in-state and out-of-state services. For the purposes of computing the MDSA, the MDSA prospective rate will be considered to be the operating per diem for the current year, prior to the application of the current year trend, plus a capital per diem and a direct medical education per diem.

(a) The prospective rate will be adjusted upward by factor of 27.169 times the difference between the actual utilization rate if it exceeds 7.94% and a 7.94% utilization rate.

(b) The prospective rate will be adjusted upward by 27.169% times the number of days above 1,000 days divided by 1,000 days.

(c) The prospective rate will be adjusted upward by 2% times the difference between the low income utilization rate if it exceeds 25% and a 25% low income utilization rate. This adjustment will be capped at 10%.

(d) Low-income utilization rate will be calculated as follows from information obtained from the latest industry complete Hospital Joint Annual Report as submitted to the State Center of Health Statistics. The sum of:

1. Total Medicaid inpatient revenues paid to the hospital, plus the amount of the cash subsidies received directly from state and local governments in a cost reporting period, divided by the total amount of revenues of the hospital for inpatient services (including the amount of such cash subsidies) in the same cost reporting period; and

2. The total amount of the hospital's charges for inpatient hospital services attributable to charity care (care provided to individuals who have no source of payment, third-party or personal resources) in a cost reporting period, divided by the total amount of the hospital's charges for inpatient services in the hospital in the same period. The total inpatient charges attributed to charity care shall not include contractual allowances and discounts (other than for indigent patients not eligible for Medical assistance under an approved Medicaid State Plan) that is reductions in charges given to other third-party payers, such as HMOs, Medicare or Blue Cross.

(e) In accordance with Section 4112 of Public Law 100-203, no disproportionate share payment will be made to hospitals that do not have at least two obstetricians with staff privileges at the hospital who have agreed to provide obstetric services to individuals entitled to such services under the State Medicaid Plan. The only exception will be made to hospitals which provide services to inpatients that are predominately individuals under 18 years of age or who did not offer non-emergency obstetric services as of December 21, 1987.

(f) Any hospital whose inpatient and outpatient charity exceeds 6% of the industry's total charity will receive an additional payment. This payment will be equal to their percentage of the industry's charity times a factor of 4.05 times the value of their charity.

(g) Any hospital that has a Medicaid utilization rate of 23% or greater and 23,000 Medicaid days or more will qualify for an additional MDSA payment. Hospitals qualifying will be allowed payment in excess of 40% of charity. Instead of a 40% limit these hospitals will receive up to a 75% limit. Any hospital qualifying for this enhancement whose ratio of charity to total revenues exceeds 30% will be capped at a total MDSA payment of $42,750,000. Any hospital whose ratio is less than or equal to 30%, will be capped at $37,750,000.

(h) Each year a redetermination of the MDSA will be made. This determination will be made on the basis of the best information available. Once the determination is made, it will not be changed until the next scheduled redetermination.

(i) The disproportionate share adjustment will be paid on a monthly basis. The monthly payment will be prospective based on the disproportionate share adjustment multiplied by the anticipated number of Medicaid days. This will be estimated based on projections from historical experience and the addition of any expected improvements.

(j) The total amount of MDSA payments will be limited by a federal cap. When allocating the amount of payments that will be made, the amount of payments made based on item (g) above, will be excluded. After calculations have been made, hospitals will receive their proportionate share of the total available MDSA allotment. The Medicaid Disproportionate Share Adjustment reimbursement for psychiatric hospitals will be included when determining the allocation.

(8) Effective July 1, 1993, only those hospitals having over 1,000 cost report patient days attributable to patients determined eligible for Medicaid by the State of Tennessee or having a Medicaid utilization ratio over 8.55% or having a low income utilization rate equal to or greater than 25% will be provided a payment incentive (MDSA). The MDSA will be the higher of the amount determined by items (a), (b), or (c), whichever is higher, and added to item (f). That total cannot exceed 40% of inpatient and outpatient charity charges plus Medicare and Medicaid contractual adjustments adjusted to cost. For the purpose of this calculation Medicaid days will not include days reimbursed by the Primary Care Network. For the purpose of this calculation charity, unless otherwise specified, will be defined as inpatient and outpatient charity charges (including medically indigent, low income, and medically indigent other), bad debt, and Medicare and Medicaid contractual adjustments adjusted to cost. Charity will include charges for both instate and out-of-state services.

(a) The prospective rate will be adjusted upward by a factor of 27.169 times the difference between the actual utilization rate and a 8.55% utilization rate.

(b) The prospective rate will be adjusted upward by 27.169% times the number of days above 1,000 days divided by 1,000 days.

(c) The prospective rate will be adjusted upward by 2% times the difference between the low income utilization rate and a 25% low income utilization rate. This adjustment will be capped at 10%.

(d) Low-income utilization rate will be calculated as follows from information obtained from the 1991 Hospital Joint Annual Report as submitted to the State Center of Health Statistics. The sum of:

1. Total Medicaid inpatient revenues paid to the hospital, plus the amount of the cash subsidies received directly from either state and local governments in a cost reporting period, divided by the total amount of revenues of the hospital for inpatient services (including the amount of such cash subsidies) in the same cost reporting period; and

2. The total amount of the hospital's charges for inpatient hospital services attributable to charity care (care provided to individuals who have no source of payment, third-party or personal resources) in a cost reporting period, divided by the total amount of the hospital's charges for inpatient services in the hospital in the same period. The total inpatient charges attributed to charity care shall not include contractual allowances and discounts (other than for indigent patients not eligible for Medical assistance under an approved Medicaid State Plan) that are reductions in charges given to other third-party payers, such as HMOs, Medicare or Blue Cross.

(e) In accordance with Section 4112 of Public Law 100-203, no disproportionate share payment will be made to hospitals that do not have at least two obstetricians with staff privileges at the hospital who have agreed to provide obstetric services to individuals entitled to such services under the State Medicaid Plan. The only exception will be made to hospitals which provide services to inpatients that are predominantly individuals under 18 years of age or who did not offer non-emergency obstetric services as of December 21, 1987.

(f) Any hospital whose charity exceeds 6% of the industry's total charity will receive an additional payment. This payment will be equal to their percentage of the industry's charity times a factor of 3.0 times the value of their charity.

(g) Any hospital that has a Medicaid utilization rate of 24% or greater and 25,000 Medicaid days or more will qualify for an additional MDSA payment. Qualifying hospitals will be allowed payment in excess of 40% of charity. Instead of a 40% limit these hospitals will receive up to a 91% limit. Any hospital qualifying for this enhancement whose ratio of charity to total revenues exceeds 30% will be capped at a total MDSA payment of $60,000,000. Any hospital whose ratio is less than or equal to 30%, will be capped at $50,000,000.

(h) Each year a redetermination of the MDSA will be made at the same time the new pass through component is determined. This determination will be made on the basis of the best information available. Once the determination is made, it will not be changed until the next scheduled redetermination. The effective date will coincide with the new pass through adjustment.

(i) In accordance with the Medicaid State Plan, the disproportionate share adjustment will be paid on a monthly basis. The monthly payment will be prospective based on the disproportionate share adjustment multiplied by the number of Medicaid days reported on the 1992 cost report. In cases where the 1992 report is still unavailable, the latest report on file will be used.

(j) The total amount of MDSA payments will be limited by a federal cap. When allocating the amount of payments that will be made, the amount of payments made based on item (g) above, will be excluded. After calculations have been made, hospitals will receive their proportionate share of the total available MDSA allotment. The Medicaid Disproportionate Share Adjustment reimbursement for psychiatric hospitals will be included when determining the allocation.

The calculation would be made in this manner: Tennessee Medicaid will total the amount of MDSA to be provided to all hospitals, both acute and psychiatric, prior to the test for the federal cap. If this total exceeds the federal cap, we will subtract from the cap amount the amount calculated as a result of item (g) (referenced above). We will take the remaining amount and divide it by the total potential MDSA for the industry less item (g) to obtain a percentage by which each hospital's MDSA payments outside of item (g) will be reduced.

I. Other Adjustments to the Prospective Rate or Prospective Payment

(1) Adjustments to the prospective rate shall be made for the following reasons:

(a) An error in computing the rate;

(b) Additional individual capital expenditures for which there is an approved certificate of need, such as the purchase of major equipment or addition of new beds, which would have an impact of 5% on the facility's total prospective rate, or a $50,000 effect on Tennessee Medicaid reimbursement.

(c) A significant change in case mix resulting in a 5% change in the facility's total prospective rate, or a $50,000 effect on Tennessee Medicaid reimbursement. Case mix, for this purpose, is a diagnostic or therapeutic related factor requiring either an increase or decrease in the professional staff per patient ratio.

(2) Providers who are seeking a rate adjustment due to additional costs and who wish to have such an adjustment effective at the same time as the additional costs are actually incurred must submit request for such adjustment to the Medicaid agency at least 45 days prior to the time the additional costs will be incurred. The effective date of such rate adjustments shall be the first day of the month following 45 days from the date of receipt of the adjustment request.

Requests for adjustment must include detailed cost information identifying the appropriate operating and pass through components.

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J. New Providers - New providers entering the Program will be required to submit a budgeted cost report from which an interim prospective rate will be set. Each new provider must submit an actual cost report covering the first full year of actual operations, at which point a final prospective rate, with a retroactive adjustment, will be set. A change of ownership does not constitute a new provider.

K. Lower of Cost or Charges Limit - In the base year, the lower of cost or charges limitation will be waived for prospective rate determination purposes only. The limitation will, however, be applied for settlement purposes for all periods prior to a facility's first fiscal year under prospective payment. Carryforwards of unreimbursed costs will not be recognized once a provider's initial fiscal year under the prospective payment methods has begun.

L. Rate Notification and Effective Dates - Beginning 30 days after October 1, 1983 each provider will be notified of their initial prospective rate at least 30 days prior to the beginning of their first fiscal year under prospective payment. The initial prospective rate shall apply to services provided on or after the first day of the provider's first fiscal year subject to prospective payment. Payment for services rendered prior to the first day of the provider's fiscal year subject to prospective payment and submitted for payment after such date shall be paid at the rate in effect during the peirod the service was rendered. Providers must split bill for services spanning the first prospective year and the prior year.

M. For payment beginning July 1, 1987, all providers will be notified of adjustment to prospective per day rate which will be the operating component only. The quarterly payment will be established in June 1987 and re-established each June of subsequent years. Providers will be notified in June of each year for the quarterly payment. Beginning January 1, 1988, providers will be paid on a monthly basis for the pass through component, resident and intern cost adjustment and Medicaid Disproportionate Share Adjustment.

Within 30 days after the receipt of each provider's cost report, each provider will be notified of their new prospective rate due to the normal pass through adjustment. This rate shall be effective by the first day of the next month one month subsequent to the date of receipt of the provider's cost report. Providers must split bill for services spanning the effective date of the rate change.